

# Individualized Education Program (IEP)

## Secondary IEP

State of Delaware

**School**

Address

Address

Phone:

**Student Name:**

**Student ID#:**

**D.O.B.:**

**Address:**

**Current Grade:**

**District of residence:**

**Attending Building:**

**Disability  
Classification:**

Primary Disability:

**Parent\* 1:**

**Address (if different):**

**Home Phone:**

**Mobile Phone:**

**Work Phone:**

**Parent\* 2:**

**Address (if different):**

**Home Phone:**

**Mobile Phone:**

**Work Phone:**

## IEP Status

<b>Meeting Date</b>		<b>Most Recent Evaluation Summary Report Date</b>	
<b>IEP Initiation Date</b>		<b>IEP Meeting History:</b>	
<b>IEP End Date</b>			

## Temporary Placement

<b>Agency Representative:</b>	
<b>Parent:</b>	
<b>Date:</b>	
<b>Within 60 days, an IEP meeting must be held.</b>	

## Meeting Participants

<b>Role</b>	<b>Name</b>	<b>Signature</b>
Parent* 1		
Parent* 2		
Administrator / Designee		
General Education Teacher		
Special Education Teacher		
CTE Teacher		

\* Parent includes legal guardian, educational surrogate parent and relative caregiver.

**Data Considerations**

1. What are the student's strengths?

Employment Strengths:

Post-Secondary Education/Training Strengths:

Independent Living Strengths:

2. What are the educational concerns of the parent (or student, if appropriate)?

3. What data sources and age appropriate transition assessments (including district or statewide assessments) are being used to create this IEP?

- ☐ Survey/Questionnaires: \_\_\_\_\_ and date administered \_\_\_\_\_
- ☐ Profiles/Portfolios: \_\_\_\_\_ and date administered \_\_\_\_\_
- ☐ Vocational Assessment: \_\_\_\_\_ and date administered \_\_\_\_\_
- ☐ Student Success Plan: \_\_\_\_\_ and date administered \_\_\_\_\_
- ☐ Other: \_\_\_\_\_ and date administered \_\_\_\_\_

4. How does the child's disability affect the child's involvement and progress in the general education curriculum?

5. What are the child's other educational needs that result from the child's disability (e.g., organizational skills, self care, fine/gross motor)?

6. Will the student participate with non-disabled students in extracurricular and non-academic areas? If yes, identify supports and services on the "Needs, Services and Annual Goals" page. If no, explain why below.

☐ Yes    ☐ No

## ***School***

Name:

DOB:

Meeting Date:

### **Other Factors to Consider:**

IEP Team must consider each of the factors.

If there is a need identified, check "Yes" and address in the IEP.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Communication needs of the student
<input type="checkbox"/>	<input type="checkbox"/>	Braille instruction for students who are blind or visually impaired
<input type="checkbox"/>	<input type="checkbox"/>	Communication and language needs for students who are deaf/hard of hearing
<input type="checkbox"/>	<input type="checkbox"/>	Language needs for the students with limited English proficiency
<input type="checkbox"/>	<input type="checkbox"/>	Positive behavior interventions, supports, and strategies for students whose behavior impedes learning
<input type="checkbox"/>	<input type="checkbox"/>	Need for assistive technology devices and services
<input type="checkbox"/>	<input type="checkbox"/>	Intervention supports and strategies for students who have difficulty accessing and/or using grade-level textbooks and other core materials in standard print formats.

## **School**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Meeting Date: \_\_\_\_\_

### **Student's Post-High School Goals:**

Post School Employment Goal	
Post School Education/Training Goal	
Post School Independent Living Goal (where appropriate)	

The student plans to exit school with:      ☐ Diploma \_\_\_\_\_      ☐ Certificate of Performance \_\_\_\_\_

### **Courses of Study:**

Grade	Courses of Study (from student's current year to year of graduation)

### **Activities and Services to reach goal:**

<b>Post School Employment Goal:</b>				
Activities/Services needed to reach goal	Responsible Party		Start Date	Completion Date

### School

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Meeting Date: \_\_\_\_\_

#### Post School Education/Training Goal:

Activities/Services needed to reach goal	Responsible Party		Start Date	Completion Date

#### Post School Independent Living Goal:

Activities/Services needed to reach goal	Responsible Party		Start Date	Completion Date

#### In addition to School Supports, the Student Will Need the Assistance of:

Agency	Contact Person	Phone Number

#### Is there a current Interagency Release of Information Form on file with the school?

☐ Yes    ☐ No    (If no, discuss form for transition planning with appropriate agencies)

## School

Name:

DOB:

Meeting Date:

### Unique Educational Needs and Characteristics #

Provide a statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will enable the child:

- to advance appropriately toward attaining the annual goals;
- to be involved in and make progress in the general education curriculum, and to participate in extracurricular and other nonacademic activities; and,
- to be educated and participate with other children with disabilities and non disabled children.

### Services, Aids & Modifications

Frequency:

Duration:

Location:

### PLEP (Present Levels of Educational Performance):

Benchmark #1

Marking Period: MP -

Benchmark #2

Marking Period: MP -

Benchmark #3

Marking Period: MP -

Benchmark #4

Marking Period: MP - 4

Annual Goal

Start Date:

End Date:

Therapist Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(For Medicaid  
Cost Recovery)

***School***

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Meeting Date: \_\_\_\_\_

**Related Services**

<b>Services</b>	<b>Type of Delivery</b>	<b>Start/End Date</b>	<b>Frequency</b>	<b>Duration</b>	<b>Location</b>

## School

Name:

DOB:

Meeting Date:

### Transportation

Special transportation needs?  If yes, specify:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is it necessary to place this student, who is transported from the school by bus into the charge of a parent or other authorized responsible person? If so, Transportation Department will be notified by:	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### Participation in Statewide Assessment

<input type="checkbox"/>	Student is not in a grade that is assessed.
<input type="checkbox"/>	Student will participate in regular testing conditions without accommodations unless one of the below is checked.
<input type="checkbox"/>	Student participates with accommodations as documented on the attached Student Accommodation Checklist.
<input type="checkbox"/>	Student is included in Alternate Assessment. The Participation Guidelines form is attached and #500 is filled in on the Student Accommodation Checklist.

### Discipline

The student will adhere to School Code of Conduct. (Check below if any of the following are needed):	
<input type="checkbox"/>	Interventions and supports are described under services/supports and/or in goals.
<input type="checkbox"/>	Behavior intervention and support plan (see attached).
<input type="checkbox"/>	Other:

### Participation in Twelve-Month Program

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
By State law [14 Del.C. §1703], parents of students with certain disability classifications may choose a 12-month program which does not exceed 217 school days (Severe Intellectual Disability; Moderate Intellectual Disability; Orthopedic Impairment; Traumatic Brain Injury; Deaf-Blind) or 241 school days (Autism). As a parent of a qualifying student, I choose a 12-month program.

### Consideration of Eligibility for Extended School Year Services (ESY)

IEP team must consider each of the following factors:		
• Regression / Recoupment	• Vocational Skills	• Degree of Impairment
• Breakthrough Skills	• Extenuating Circumstances	
<b>Is ESY needed?</b>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> To Be Determined
<input type="checkbox"/> ESY offered, but declined by parent		
Rationale for Decision:		
Specify goals and services:		



## School

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Meeting Date: \_\_\_\_\_

### Least Restrictive Environment/Placement

A student with a disability shall not be removed from an education setting in age appropriate regular classes solely because of needed modifications in general education curriculum. Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

Use the option below to determine the appropriate setting.

<input type="checkbox"/>	A.	<b>Regular Setting</b> Includes pull-out related services and team classrooms. Student served inside the regular classroom greater than or equal to 80% of the day.
<input type="checkbox"/>	B.	<b>Services Provided Both in Separate Special Education Classes and Regular Setting</b> Student served inside the regular classroom greater than or equal to 40% of the day and no more than 79% of the day.
<input type="checkbox"/>	C.	<b>Separate Special Education in an Integrated Setting</b> Student served inside the regular classroom less than 40% of the day.
<input type="checkbox"/>	D.	<b>Separate School</b> Student served in public or private separate day school facility for greater than 50% of the school day or a residential facility if student does not live at the facility.
<input type="checkbox"/>	E.	<b>Residential Facility</b> where student resides during the school week.
<input type="checkbox"/>	F.	<b>Homebound or Hospital</b>
<input type="checkbox"/>	G.	<b>Correctional Facilities</b> (only used by DSCYF and Prison Education) Students placed in short-term detention or correctional facilities.

An explanation must be provided about the extent, if any, to which the child will not participate with nondisabled children in the regular class.

### Signatures

<input type="checkbox"/> Yes	<input type="checkbox"/> No	I acknowledge that I have received a copy of the Procedural Safeguards. My due process rights under these Procedural Safeguards have been explained to me.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I agree with the program described in this document:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I agree with the placement decision as noted above and discussed at this meeting.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	At least one year before the age of majority (18), the student has been informed that rights will transfer to him/her unless a legal guardian has been appointed

\_\_\_\_\_  
Parent/Student Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Parent/Student Signature\_\_\_\_\_  
Date

### If Parent Does Not Attend

Staff member below is responsible for forwarding a copy of the IEP and Procedural Safeguards and explaining content, if necessary, to the Parent/Guardian/Surrogate.

\_\_\_\_\_  
Name\_\_\_\_\_  
Position\_\_\_\_\_  
Method of Contact